



PEBB Medicare Advantage Plan Disenrollment Form

This is a request to disenroll from a PEBB Medicare Advantage plan.

This form must be processed by the Health Care Authority before your plan change can be effective.

(Please print in black ink.)

I wish to disenroll from:	
Medical plan (Check one.) <input type="checkbox"/> Group Health Medicare Advantage Classic <input type="checkbox"/> Group Health Medicare Advantage Value <input type="checkbox"/> Kaiser Permanente Senior Advantage Classic <input type="checkbox"/> Kaiser Permanente Senior Advantage Value <input type="checkbox"/> Secure Horizons Classic <input type="checkbox"/> Secure Horizons Value	Effective date of change
Subscriber's name	Date
Subscriber's signature	
Medicare number	
Spouse or same-sex domestic partner's name	Date
Spouse or same-sex domestic partner's signature	
Medicare number	

Washington State law may require disclosure of any information you submit as a public record.
The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or
online at www.hca.wa.gov.

Please return this form to:

Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684



**Washington State
Health Care Authority**
Public Employees Benefits Board

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